

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2478AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2009
NAME OF PROVIDER OR SUPPLIER SUN VALLEY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 220 CARLIN AVE LAS VEGAS, NV 89110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 8/25/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility was licensed for six (6) Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 5 residents. Five (5) resident files were reviewed and three (3) employee files were reviewed. One (1) discharged resident file was reviewed. The facility received a grade of A.</p> <p>There were no complaints investigated.</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 105 SS=E	<p>449.200(1)(f) Personnel File - Background Check</p> <p>NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.</p> <p>This Regulation is not met as evidenced by: Based on record review on 8/25/09, the facility</p>	Y 105		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 105	Continued From page 1 failed to ensure 1 of 3 caregivers met background check requirements (Employee #2 -most recent fingerprints & criminal history response was dated 3/4/04). Severity: 2 Scope: 2	Y 105			
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This Regulation is not met as evidenced by: Based on record review on 8/25/09, the facility failed to ensure that 2 of 5 residents received a pre-admission physical (Resident #3 and #5). Severity: 2 Scope: 2	Y 859			
Y 870 SS=E	449.2742(1)(a)(1)(2)(b)(c) 449.2742(1)(a)(1) Medication Administration NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the	Y 870			

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Y 936	<p>Continued From page 4</p> <p>that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation:</p> <p>(e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.</p> <p>This Regulation is not met as evidenced by: Based on record review on 8/25/09, the facility failed to ensure 1 of 5 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #3) which affected all residents.</p> <p>Severity: 2 Scope: 3</p>	Y 936		

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